**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

| | |
|---|---|
| Requestor Name and Address:<br>STAT 2000<br>P O BOX 15640<br>FORT WORTH TX 76119 | MFDR Tracking #: M4-05-0340-01<br>DWC Claim #:<br>Injured Employee: |
| Respondent Name and Box #:<br>AMERICAN HOME ASSURANCE COMPANY<br>Box #: 19 | Date of Injury:<br>Employer Name:<br>Insurance Carrier #: |

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Requestor's Position Summary:** "We have submitted a claim to the Carrier for date of service 09-10-03 for one month rental of the BMR NT2000 Neuromuscular Stimulator. The disputed issue is that the Carrier paid $111.89 stating reimbursement according to the Texas Medical Fee guidelines. We resubmitted the claim to the Carrier requesting an additional payment. The Carrier denied additional payment stating the same… we feel that additional payment is due. We have billed for the rental of the unit using the miscellaneous HCPCS code E1399. We have used this code according to the manufacturer, as there is not an appropriate HCPCS code available to use. The BMR NT2000 is more than a neuromuscular stimulator, electronic shock unit. This unit can be programmed for two forms of treatment (i.e. acute-pain program and an option for muscle relaxation treatments). Rule 134.202 states in part that if Medicare and Medicaid does not have a fee schedule amount then values will be established based in part on commission medical dispute decisions. There have been innumerable decisions upholding $150.00 as a fair and reasonable amount for the monthly rental of the unit. The $150.00 fee is also based on the old DME Ground Rules stating to use 'D' codes. The rental reimbursement rate of $150.00. I am enclosing a detailed description of the services rendered."

**Principal Documentation:**

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Manufacturer Product Documentation of BMR NT2000 Neuromuscular Electrical Stimulator
5. Total Amount Sought - $133.11

## PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Respondent's Position Summary:** "The Provider submitted billing for a Neuro-muscular Stimulator. The Carrier reimbursed the Provider per fee schedule for the stimulator. The Carrier reimbursed the Provider for Neuro-Muscular Stimulator, Electronic Shock Unit…The Provider is requesting additional reimbursement; however, they have failed to provider [sic] evidence describing the differences between an NT2000 and an ordinary muscle stimulator."

**Principal Documentation:**

1. Response Package

## PART IV: SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Calculations | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| 9/10/2003 | E1399-One month rental BMR NT2000 Neuromuscular Electrical Stimulator | N/A | $133.11 | $0.00 |
| | | | **Total Due:** | $0.00 |

## PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. This request for medical fee dispute resolution was received by the Division on September 8, 2004. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on September 15, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
2. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
3. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
4. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment.
5. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.
6. Division rule at 28 TAC §133.304, effective July 15, 2000, 25 TexReg 2115, requires the insurance carrier to develop and consistently apply a methodology to determine fair and reasonable reimbursement.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 11/07/2003

   - F—Reimbursement according to the Texas Medical Fee Guidelines.

   Explanation of benefits dated 11/20/2003

   - O—Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time. Bill has been paid accodring [sic] to State Fee Guidelines and/or State Rules and Regulations.

**Issues**

1. What is the applicable rule for reimbursement?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. Division rule at 28 TAC §134.202(c)(2) states "for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection." HCPCS code E1399 is described as "Durable Medical Equipment, miscellaneous". The requestor noted on the medical bills that HCPCS code E1399 was for a "NT 2000 Muscle Stimulator Rent." Neither the DMEPOS fee schedule nor the Texas Medicaid Fee Schedule has a set fee for HCPCS code E1399.

   Division rule at 28 TAC §134.202(c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." The Division finds that HCPCS code E1399 does not have an established relative value or payment amount. The insurance carrier did not submit documentation to support that the carrier has assigned a relative value.

   Division rule at 28 TAC §134.202(d) states "In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)."

   Division rule at 28 TAC §134.1, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

Review of the documentation submitted by the parties to this dispute finds no documentation to support that an amount was pre-negotiated and/or contracted between the provider and carrier for the disputed HCPCS code E1399; therefore, the insurance carrier shall reimburse the provider the fair and reasonable rate in accordance with Division rule at 28 TAC §134.1.

2. Division rule at 28 TAC §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "There have been innumerable decisions upholding $150.00 as a fair and reasonable amount for the monthly rental of the unit."
   - The requestor did not submit copies of or citations to Division decisions upholding $150.00 as a fair and reasonable amount for the monthly rental of the disputed service.
   - The requestor's position statement asserts that "The $150.00 fee is also based on the old DME Ground Rules stating to use "D" codes. The rental had a reimbursement rate of $150.00."
   - The requestor did not submit documentation to support that the rental rate for a comparable service was set at $150.00 in the 1991 Medical Fee Guideline Durable Medical Equipment (DME) Ground Rules.
   - The requestor did not reference a specific "D" code or submit documentation to support that the disputed service was comparable to any of the codes listed in the 1991 DME Ground Rules.
   - Review of the 1991 DME Ground Rules finds no comparable code to the disputed service and no "D" code listed with a rental rate of $150.00.
   - The requestor did not submit documentation to support that payment of the amount sought would result in a fair and reasonable rate of reimbursement.
   - The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas labor Code §413.011(d) or Division rule at 28 TAC §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

**PART VI: ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

| Authorized Signature | Medical Fee Dispute Resolution Officer | **June 30, 2010** |
|---|---|---|
| | | Date |

**PART VII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**